Ways forward for WHO in reducing the harmful use of alcohol worldwide

Room, Dr Robin, Centre for Alcohol Policy Research, La Trobe University, Melbourne, Australia
Babor, Dr Tom, University of Connecticut School of Medicine, Farmington, Connecticut, USA
Casswell, Prof Sally, SHORE, Massey University, Auckland, New Zealand
Jernigan, Prof David, Boston University School of Public Health, Boston, Massachusetts, USA
Rehm, Dr Jürgen, Centre for Addiction and Mental Health (CAMH), Toronto, Ontario, Canada

Ways forward for WHO in reducing the harmful use of alcohol worldwide

In 2005, the World Health Assembly adopted resolution 58.26, on "Public health problems caused by the harmful use of alcohol", recognizing that "the patterns, context and overall level of alcohol consumption influence the health of the population as a whole, and that harmful drinking is among the foremost underlying causes of disease, injury, violence – especially domestic violence against women and children – disability, social problems and premature deaths, is associated with mental ill-health, has a serious impact on human welfare affecting individuals, families, communities and society as a whole, and contributes to social and health inequalities" (WHA, 2005). This was followed up in 2010 by the adoption of a "Global strategy to reduce the harmful use of alcohol" (WHO, 2010). Within the context of this Strategy, in 2018 WHO introduced SAFER, a technical package of policy initiatives aiming to prevent and reduce alcohol-related harms (WHO, 2018b).

In the last decade, there have also been relevant international program developments beyond the frame of the alcohol strategy. These have included, first, a substantial new emphasis by the United Nations and WHO on preventing premature deaths from Non-Communicable Diseases (NCDs) – defined as comprising cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases (UN, 2011; WHO, 2019b). For several of these diseases alcohol consumption is an important risk factor (Rehm et al., 2018), and consequently WHO identified alcohol as one of the four most important risk factors for NCDs (WHO, 2013). WHO's program against NCDs thus included a goal of "at least a 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context" by 2025 (WHO, 2013:34). Also in a wider United Nations context, the Sustainable Development Goals, adopted in 2015 for the period until 2030, widened the definition of NCDs (target 3.4 and its indicators) and mentioned alcohol specifically in the context of health (target 3.5). Beyond this, it has been argued that alcohol is also an impediment across a broader range of the goals (Collin & Casswell, 2016; Dünnbier & Sperkova, 2016).

At its 2020 meeting, the World Health Assembly will consider where things stand with respect to the implementation of the global strategy for alcohol, and the way forward (WHO, 2019a). This paper is written in that context, to reflect on global experience in recent years of trends in alcohol consumption, problems and countermeasures, and adoption and implementation of effective policies, and to consider potential ways forward for the World Health Organization and others involved in efforts to reduce alcohol-related harm.

The paper first considers the importance of alcohol as a risk factor in the global burden of disease, considering what has happened in recent years with respect to trends in alcohol consumption and the alcohol-attributable burden of disease. We then turn to adoption of and new developments in policies and programs to reduce alcohol-related harm, and what can be said about their impact as well as barriers to date to their effective implementation. Finally, we propose and discuss new initiatives at global, national and other levels for implementation in the next decade.

ALCOHOL USE AS A RISK FACTOR FOR HEALTH GLOBALLY

In all global comparative risk analyses since the original study of Murray and Lopez (1996), alcohol use was among the top ten risk factors (Rehm & Imtiaz, 2016). It is particularly significant as a risk factor among men, reflecting gender differences in alcohol consumption. A comparison over time between 1990, 2007 and 2017 found that alcohol's ranking among risk factors for health had not fallen, and indeed if

anything had risen over time (GBD 2017 Risk Factor Collaborators, 2018), particularly in low and middle-income countries.

Alcohol use substantially contributes to ill-health in both high- and lower-income countries (WHO, 2018a). Figure 1 shows the patterns by major disease and injury categories, grouped by national income. The highest levels of alcohol-related mortality are in the lower-middle income group of countries. Alcohol's contribution is generally higher among middle-income than low-income countries, in line with a tendency for alcohol's proportional contribution to ill-health to rise with economic development. Figure 1 also illustrates the diversity of contributions of alcohol to the burden of disease across all four of the major disease burden categories – injuries, mental health, other non-communicable diseases, and infectious diseases.
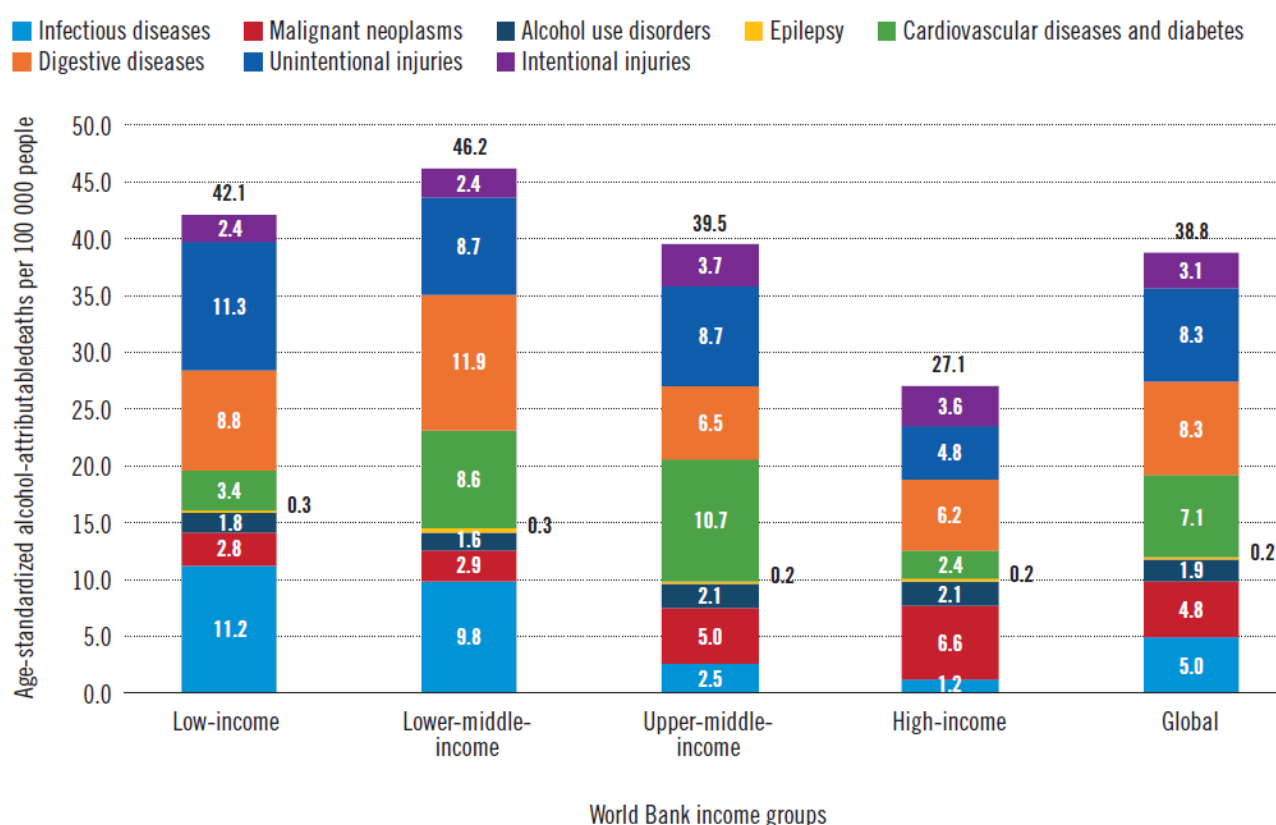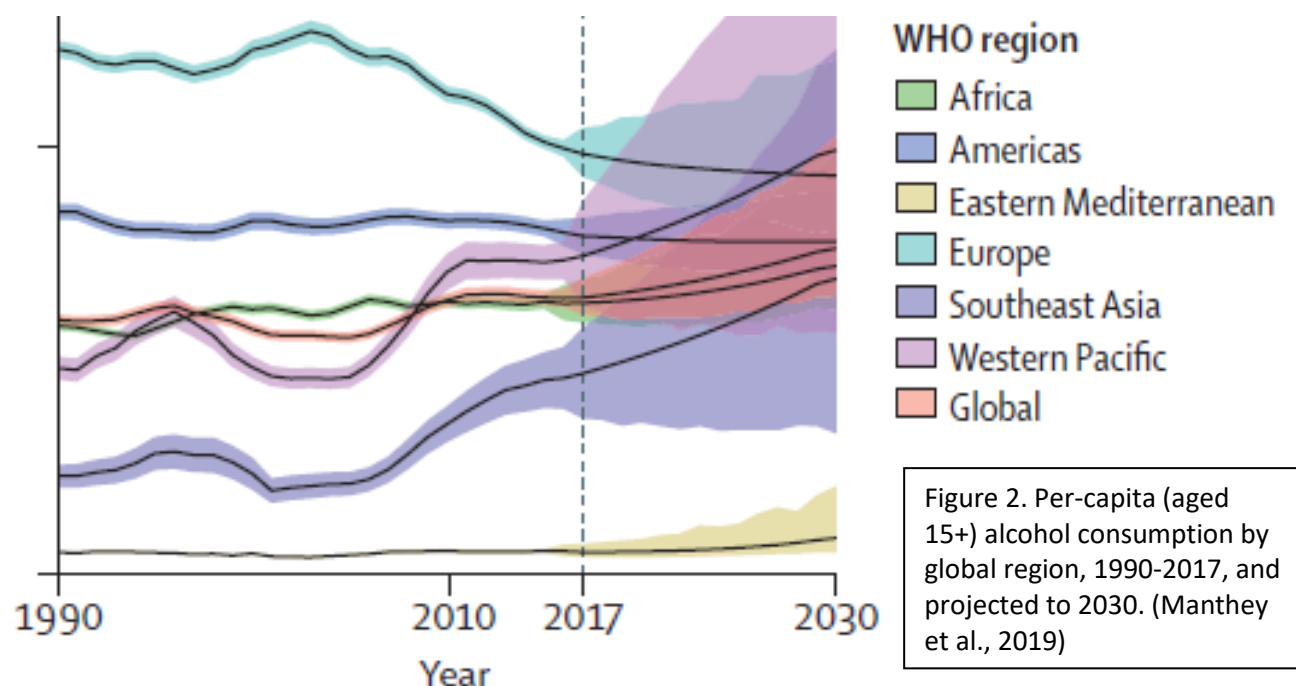

Figure 1. Alcohol-attributable deaths by disease or injury condition, by national income group and globally (WHO, 2018a: 82; the legend, read left to right, shows categories from the bottom up)

Within countries, alcohol-attributable harm is higher for lower social strata, even in countries where average level of consumption is not higher in these strata (Katikireddi et al., 2017; Probst et al., 2018).

WHAT CAN BE SAID ABOUT RECENT GLOBAL TRENDS?

Though alcohol's relation to health harms varies somewhat by pattern of drinking (Rehm et al., 2017), in general changes in the adult (age 15+) *per capita* consumption of alcohol (APC) in any country at a particular historical time are a strong indicator of an increase or decrease in alcohol's contribution to disease and injury. In line with this, WHO's Global Action Plan for the Prevention and Control of NCDs 2013-2020 (WHO, 2013) uses APC as the indicator to measure the target for reduction of harmful alcohol use for 2025. Figure 2 shows that on a global level the APC consumption increased somewhat between 1990 and 2012, and has since been more or less steady.

Any global target for the reduction of alcohol use may not do justice to regional and national developments. As Figure 2 shows, there are different trends in alcohol use by WHO region (in considerable part driven by economic development). The WHO European region -- with many high-income countries -- has been reducing alcohol use over the past one and a half decades, while Asian regions including China and India have increased alcohol consumption during that time span (Manthey et al., 2019). This situation has led to discussion about a need for specific regional goals.

Figure 2. Per-capita (aged 15+) alcohol consumption by global region, 1990-2017, and projected to 2030. (Manthey et al., 2019)

DEVELOPMENT IN POLICIES AND PROGRAMS TO REDUCE THE BURDEN FROM ALCOHOL CONSUMPTION

WHO's reports and technical packages on alcohol described above have recommended a number of strategic areas and policy measures to Member States. Thus WHO's 2010 Global Strategy to Reduce the Harmful Use of Alcohol (WHO, 2010) laid out and discussed ten areas for national action:

1. leadership, awareness and commitment;
2. health services' response;
3. community action;
4. drink-driving policies and countermeasures;
5. availability of alcohol;
6. marketing of alcoholic beverages;
7. pricing policies;
8. reducing the negative consequences of drinking and alcohol intoxication;
9. reducing the public health impact of illicit alcohol and informally produced alcohol;
10. monitoring and surveillance.

Later, in the context of strategies for reducing a major risk factor for NCDs, WHO zeroed in on "best buys" and listed additional recommended interventions to reduce harmful alcohol use, specifying actions from within areas 5, 6, 7 of this list (WHO, 2017b). "Best buys" were defined on the basis of high cost-effectiveness and ease of implementation, in particular in low-income countries (WHO, 2017b; Chisholm et al., 2018). They comprise:

* Increase excise taxes on alcoholic beverages;

4

* Enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media);
* Enact and enforce restrictions on the physical availability of retailed alcohol (via reduced hours of sale);

The wider group of other recommended policies adds the following two interventions, which are clearly less cost-effective (Chisholm et al., 2018):

* Enact and enforce drink-driving laws and blood alcohol concentration limits via sobriety checkpoints;
* Provide brief psychosocial intervention for persons with hazardous and harmful alcohol use.

With some variation in wording, WHO's SAFER initiative provides essentially the same list of five actions to be taken (WHO, 2018b). The overall research support for the measures varies, with clearly the strongest evidence for increases in taxation and restrictions of availability (Babor et al., 2010), but with all three "best buys" having recently been determined to be both effective and cost-effective (Chisholm et al., 2018).

However, as discussed in more detail below, action at national or subnational levels on these measures has occurred systematically in only a few instances, and there is no present sign that this pattern is changing. One obvious problem is the relative paucity of funding for global leadership and collaboration at intergovernmental level and among civil society on action and evaluation concerning reducing alcohol-related harm. At a global level, the World Health Organization remains the only intergovernmental agency with a continuing program of work specifically devoted to reducing alcohol-involved problems (Casswell, 2019b; Room, 2019). Much of WHO's work overall is financed by extrabudgetary funds, but the amount of such funds WHO receives for work on alcohol, whether from governments or from philanthropists, is very limited. The commitment of core budget funds by WHO is also limited, so that in recent decades less than a handful of fulltime-equivalent professional staff have worked at any one time on alcohol issues in WHO, whether in the headquarters or in regional offices (Room, 2005a; Gostin et al., 2015). This compares, for instance, with dozens of staff working on tobacco issues at the secretariat of the Framework Convention on Tobacco Control or at WHO, and hundreds working on illicit drug control issues for the UN Office of Drugs and Crime and regional intergovernmental drug authorities.

Considering its very limited staffing for alcohol issues, WHO accomplishes quite a lot on them. But WHO's alcohol programme is far short of what would be justified by alcohol's status as a substantial and fungible global risk factor for health.

WHAT SUCCESS WORLDWIDE AND AT THE COUNTRY LEVEL IN REDUCING HARM FROM ALCOHOL?
<u>Limited progress worldwide in the era of the Global Strategy on alcohol</u>

Data from surveys of WHO Member States – a 2015 questionnaire dedicated to progress on alcohol policies since 2010 answered by 138 member states (Jernigan & Trangenstein, 2017), and the 2016 Global Survey on Alcohol and Health, to which 173 member states responded (WHO, 2018a) – indicate that progress on the ten key areas outlined in the Global Strategy has been spotty at best. Notably, the least progress has been made on the three best buys of restricting availability, reducing marketing and raising prices. Of the three, countries were most active on prices (36% of countries responding), largely due to interest in the revenues alcohol tax increases may produce. However, there appears to be little awareness of tax increases as a public health strategy, and two-thirds (68%) of countries with alcohol excise taxes do not tie them to inflation, so without an annual increase the taxes are likely to decline in real value. Regulation of marketing has trended slightly in a more restrictive direction, but the least restrictive policies are still the most common, and government regulation of internet and social media-based marketing is
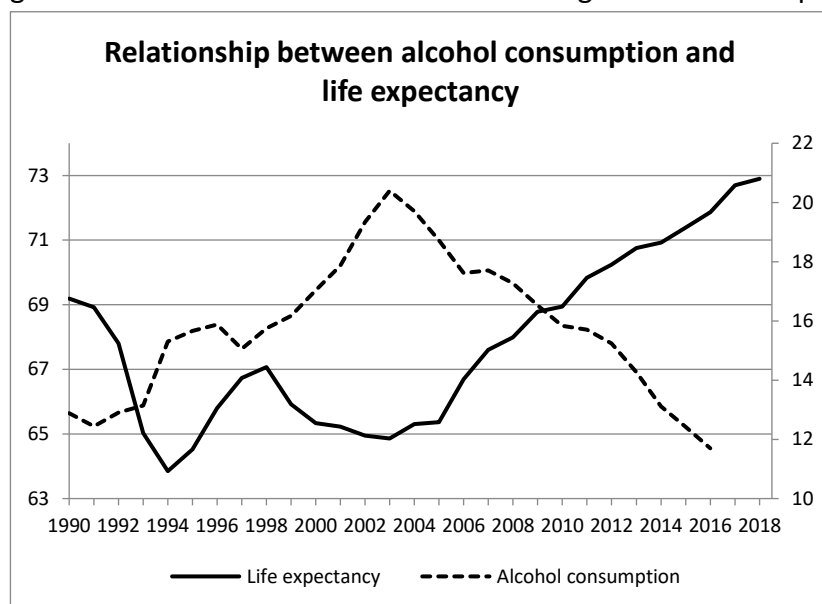
least common (present in 37% or fewer of reporting countries). Regarding physical availability, since 2010 ten countries have increased the minimum purchase age for alcohol, but overall there were declines from 2008 to 2016 in restriction of both alcohol outlet density and days of sale.

In recent years, there have been some fairly widespread signs of progress in alcohol consumption patterns in particular populations. Drinking by teenagers seems to have declined in a wide range of high-income countries (Kraus et al., 2018; Pape et al., 2018), although it is not yet clear how much this decline will persist beyond the teenage years. But discussions and analyses of what lies behind these changes (e.g., Kraus et al., 2019), while still not decisive, certainly do not point to policy changes impelled by the Global Strategy. And at the same time, there have been substantial increases in drinking in middle-income countries, as indicated by trends in Figure 2, so that the net APC on a global level has not declined.

Some "success stories" at the national level

Case study 1. Russia

The Russian Federation is arguably the country where alcohol consumption has been most closely linked with overall mortality and life expectancy (see Figure 3). After a period of restrictions on alcohol availability in the last years of the Soviet Union, consumption rose steeply. In an eventual response to this, the government of the Russian Federation brought in a series of policy measures to drive down consumption.

Relationship between alcohol consumption and life expectancy

Figure 3. Trends in life expectancy in years (left scale) and total alcohol consumption in litres per capita (right scale). Adapted from: Nemtsov, Neufeld and Rehm, 2019.

In its experience in recent decades, Russia serves as a case study in how evidence-based alcohol policies can decrease consumption and alcohol-attributable mortality, leading to historic peaks of life expectancy.

A new study by the World Health Organization Europe (2019; Nemtsov et al., 2019) revealed that total per capita

consumption has been declining since 2003 and dropped by 43% by 2016, with a 40% decline in recorded consumption and a 48% decline in unrecorded consumption (i.e. consumption of untaxed alcohol that is produced, distributed and sold outside the formal channels under governmental control). At the same time, all-cause mortality has been steadily declining, dropping by 39% in men and by 36% in women between 2003 and 2018, with the most pronounced relative changes occurring in deaths causally linked to alcohol consumption.

Detailed analyses over the time period revealed that the more intensive the implementation of known effective alcohol policies to be effective-- such as marked increases in levels of taxation and minimum unit prices to stop the increase in affordability of alcoholic beverages, restrictions on availability and marketing, and cutting down unrecorded consumption -- the more accelerated was the decline in mortality (see Figure 4).
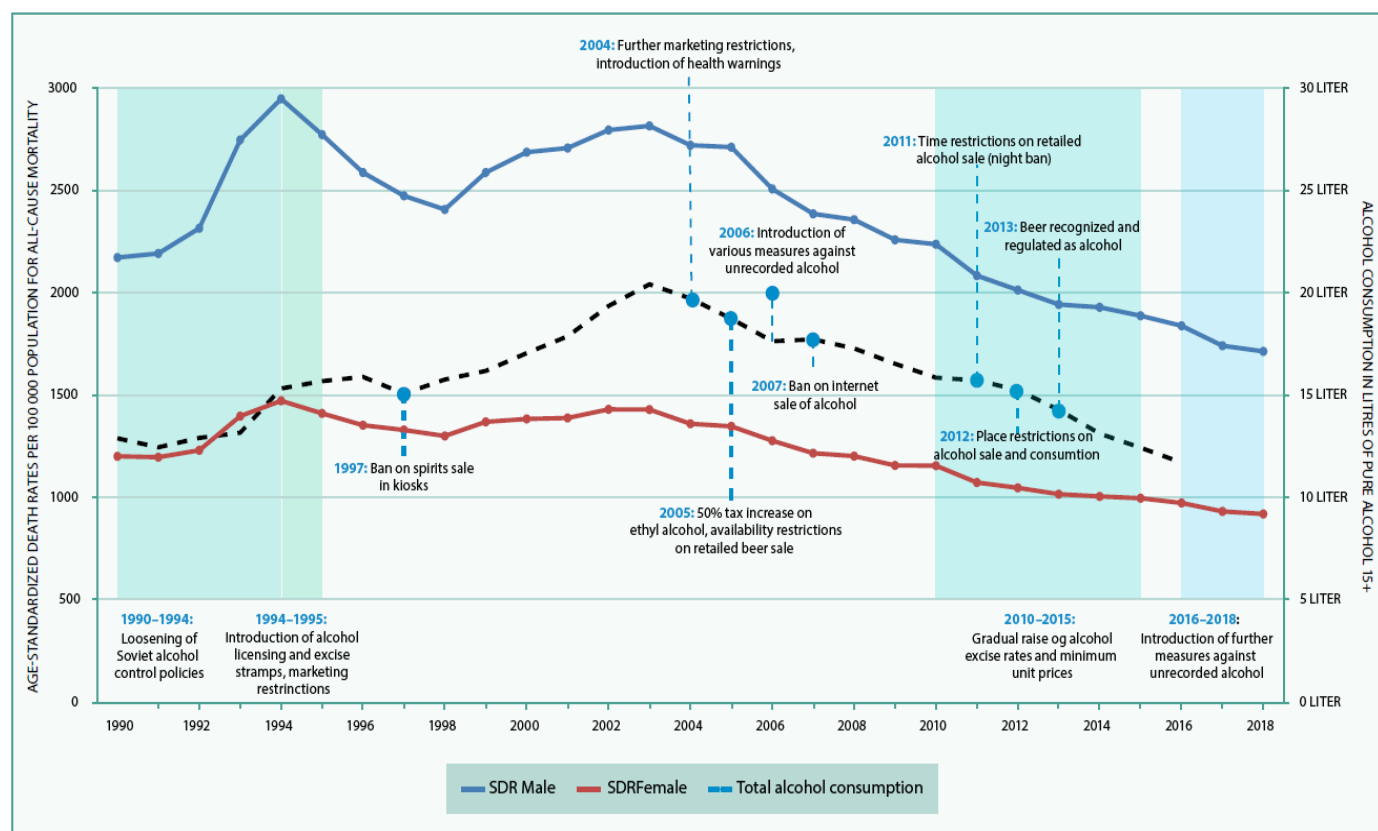
Figure 4. Age-standardised death rates for males and females 1990-2018 (left scale) and alcohol consumption per capita aged 15+ 1990-2016 (right scale) in the Russian Federation. Policy interventions indicated by the year initiated. (WHO Europe, 2019)

Case study 2: Lithuania

Lithuania was the only high-income country which recently implemented all three "best buys" for reducing alcohol-attributable health burden within a short time period, between March 2017 and February 2018, in addition to various other evidence-based alcohol measures such as increasing the legal age of consumption or drink-driving measures (Rehm et al., 2019a; 2019b). While final data are not available yet to fully evaluate the impact of these reforms, first results indicate a marked reduction in alcohol-attributable collisions and crashes, injury and deaths. All indicators decreased consistently and significantly after the implementation of alcohol control measures. On average, each implemented policy measure permanently reduced the proportion of alcohol-attributable crashes by 0.55% (95% Confidence Interval (CI): 0.21-0.90%; p=0.002), the proportion of alcohol-attributable injuries by 0.60% (95% CI: 0.24-0.97%; p=0.001) and the proportion of alcohol-attributable deaths by 0.13% (95% CI: 0.10-0.15%; p<0.001; Rehm et al., 2019a; 2019b).

Case study 3: Estonia

In Estonia, there was a substantial increase in APC from 9.3 litres in 2000 to 14.8 litres in 2007, but thereafter the APC declined to 10.2 litres in 2016 (Parna, in press). The decline in consumption was partly due to a sustained policy of excise tax increases – there were ten increases between 2005 and 2017 – and a 2008 restriction of hours of sale of alcoholic beverages, but also reflected a substantial economic recession in 2008. Estonia had joined the European Union in 2004, and this somewhat limited the possibilities for alcohol control, with unrestricted cross-border shopping dampening the effect of rises in

alcohol excise taxes. Thus further rises in alcohol taxes in 2018 and 2019 were cancelled to counter the extensive cross-border shopping in Latvia.

The relation of the WHO Global Strategy to the Russian and Baltic states cases

In the aftermath of the dissolution of the Soviet Union, alcohol consumption rose steeply in the successor states, partly reflecting a popular reaction against the top-down controls of the Gorbachev era, and partly stemming from the end of market controls with the dissolution. Thus the Russian Federation and the three Baltic states were among the countries with the highest APC levels globally in this period (Shield et al., 2016). Governments in Russia, Lithuania and Estonia recognised their populations' substantial problems with alcohol, and took various actions to reduce the level of APC and alcohol-induced problems. The World Health Assembly's adoption of the Global Strategy on alcohol may have provided some external support for policy changes already under way in the Russian Federation, but the policy changes primarily reflected internal dynamics and decisions. The decline in consumption started in 2003, well before the WHO Global Strategy was adopted. The policy changes in Lithuania and Estonia were more influenced by the Global Strategy and subsequent WHO documents (e.g., Estonian Ministry of Social Affairs, 2014). But the Estonian experience underlines that public health-oriented national changes in alcohol policy can be substantially hindered if neighbouring countries fail to make such changes.

CHALLENGES IN REDUCING THE HARMFUL USE OF ALCOHOL WORLDWIDE AND AT A COUNTRY LEVEL
 Key challenges include the following:

1. Industry resistance to and subversion of public health interests. Alcohol industry interests have long sought to influence alcohol policies and minimise effective controls on the alcohol market but the growth in size and global networking of the supranational alcohol corporations (Jernigan & Babor, 2015) has expanded their capacity and success in subverting effective public health policy. The influence has taken many forms, even extending, as documented for national alcohol policy documents in four African countries, to employing consultants to write the policy documents (Bakke & Endal, 2010). Babor et al. (2015) have documented in a broader frame the strong influence alcohol industry interests have had in broadening the availability of alcohol in African nations, while Esser and Jernigan (2015) have described industry activities in India.

In the context of international agencies and forums, alcohol industry interests often succeed in influencing national delegations. In the "technical barriers to trade" discussions at the World Trade Organization, for instance, national representatives frequently speak and act on behalf of alcohol interests in their country (e.g., O'Brien and Mitchell, 2018). As Gopakumar (2019) points out, participation of the private sector even as observers can influence the outcome of norms and standard-setting proposals. As a report of the WHO Secretariat put it, "interference by industry interests impedes the implementations of the best buys and other recommended interventions, including raising taxes on tobacco, alcohol and sugar-sweetened beverages" (WHO Executive Board, 2017). For example, the outcome document of the 2017 WHO Global Conference in Montevideo on a roadmap for 2018-2030 for NCDs (WHO, 2017a) dropped proposals for taxation of sugar-sweetened beverages and alcohol which had been included in the draft document.

Case study: Vietnam

During the past three decades consumption of alcohol in Vietnam has increased dramatically (Lincoln, 2016; WHO, 2018), the highest increase since 2010 in litres APC in any large country (Manthey et

al., 2019). In 2018 legislation drafted by the Ministry of Health, with some support from WHO, was disseminated for consultation; this draft included the three 'best buys' of alcohol control (WHO, 2017b). Industry players -- supranational alcohol corporations such as Heineken and Pernod Ricard, and trade organisations such as the Vietnam section of the International Alliance for Responsible Drinking -- were very active in the Vietnamese policy environment during the period of consultation. These commercial interests were supported by the American and European Chambers of Commerce. The methods of influence included making donations, public-private partnerships especially with government committees, co-hosting workshops, and written submissions and letters opposing specific provisions and suggesting alternative wording which were sent directly to the Prime Minister and National Assembly members.

Following a period of intensive involvement from the alcohol industry, in 2019 the National Assembly passed an Act which included only minimal restrictions on beer marketing (Slezak, 2019; VNS, 2019). Lost from the legislation were restrictions on trading hours, and a health promotion agency funded by an earmarked tax.

2.   Industry-influenced framing of alcohol problems. The alcohol industry's preferred framing of alcohol problems is as an issue involving a small minority of the population, and as a matter of individual responsibility which can be dealt with by promoting "responsible drinking". This framing is put forward by the industry's corporate social responsibility organisations (Casswell, 2009). It is reflected in terminology in the current WHO Global Strategy, phrased in terms of "harmful use of alcohol" rather than of more direct phrases such as "alcohol control" or "prevention of alcohol-related harms". Health and social problems due to drinking, whether the harms are to the drinker or to others, are widely dispersed in populations, with a substantial fraction of the harms attributable to drinkers who are well below the top end of the alcohol consumption distribution in the population (the "prevention paradox"; Rossow & Romelsjö, 2006). Health and social harms related to lesser levels of drinking are easily left out when problems are framed in terms of "harmful use of alcohol."

3.   Weakness of global actors from civil society in the alcohol policy field. In recent years civil society organizations, academics and public health professionals from many countries have formed a loose informal global health network attempting to reduce alcohol harm within a public health framework (Schmitz, 2015). The network has been partially successful in supporting WHO in its efforts to implement the Global Strategy, but it has not been nearly as large or effective as groups working in tobacco control. Whereas the global tobacco network was able to create and maintain a consensus on policy solutions, a similar network in the alcohol field has struggled with expanding its reach in part because of engagement of some participants with the alcohol industry (Gneiting and Schmitz, 2016).

4.   Trade agreements and disputes treating alcohol as an "ordinary commodity": In the treaties of the World Trade Organization and in nearly all multi- and bilateral trade agreements, alcohol is treated as an ordinary commodity. As this system of free-market and investment treaties and jurisprudence has grown in recent decades, government controls on domestic alcohol markets have come under increasing critique from alcohol industry interests, often through trade departments of other governments acting on their behalf. There is both a lack of capacity among smaller nations to negotiate within a multilateral trade agreement and a chilling effect from a threat of a lawsuit financed by a multinational firm: the potential cost of a defence is more than a government is willing to pay. Alcohol policy can potentially be affected by many chapters of a trade agreement, for example chapters on transparency and regulatory coherence may

give leverage to 'stakeholders' demanding a right to influence alcohol policies, complaining if they are excluded or marginalized from the policy-making process, and forcing the government to engage and counter their arguments explicitly. In the context of alcohol policies, the intended 'stakeholders' or 'interested parties' are not the public health community; they span the commercial interests promoting manufacture, distribution, pricing and sale, the advertising industry, communications media and parts of the sports industry, along with well-resourced 'social aspects' organizations (Kelsey 2012).

A current substantially contested area is requirements of warning labels on alcohol bottles and cans. There have been a number of WTO disputes about warning labels as "technical barriers to trade" (O'Brien & Mitchell, 2018), and efforts by industry interests -- and governments acting on their behalf – to get provisions in treaties that would allow such warnings to be relegated to "supplementary labels" (O'Brien et al., 2017).

5. Digital and satellite marketing. As evidence has grown of the association between exposure to alcohol marketing of various kinds and youth drinking behaviour (Jernigan et al., 2017), national governments have faced a growing challenge from digital and cross-border marketing. Satellite television permitted exposure to alcohol marketing in places like Europe, where signals easily crossed national borders. However, the situation has worsened as the alcohol industry has increasingly moved to investing in digital marketing and using social media platforms. The social media platforms are profit-making businesses with infrastructure designed to allow 'native' marketing (brand content which is indistinguishable from other content) that is data driven and participatory (Carah et al., 2018). The platform's data on users reveals a user's interest in alcohol consumption and its relation to specific times, places and cultural interests (like sport or music) and brand content – material which is seamlessly embedded in larger cultural narratives on the platform (Niland et al., 2017). Brands also work through influencers who may or may not reveal their pecuniary interest. An indication of the degree to which alcohol companies have moved to these media may be gleaned from the industry's spending. While global figures are unavailable, *Advertising Age* estimated expenditures in the U.S. market. In 2017, the largest alcohol marketer, Anheuser-Busch Inbev, spent an estimated US$595 million in the traditional measured media of broadcast, print and outdoor billboards, while the company put US$947 million into digital marketing (Advertising Age-Neustar, 2018).

Internet marketing crosses borders with even greater ease than satellite television and is not easily subjected to national level control. Of 173 countries that reported regulation of marketing in social media to WHO in 2016, just 22 ban it, and those bans are most likely to be effective in places like Russia, Finland and Turkey, where the dominant language does not easily transcend borders. In much of the world, in contrast, countries depend on alcohol industry self-regulation and/or the practices of the major platforms themselves to conform to the local laws. Age controls in these media are weak or non-existent, and alcohol companies have already gotten into trouble both for exposing youth (Handley, 2018) and for engaging in practices such as influencer marketing. where their sponsorship, and even the fact that marketing is happening, is not transparent (Fickensher, 2018).

6. Alcohol as "our drug" for elites nearly everywhere. "Alcohol brands are often a symbol of luxury – among the few cross-cultural symbols of luxury foodstuffs offered, for instance, unstintingly to persons in the first-class cabin on an airplane" (WHO, 2018:131). Alcohol is a frequent accompaniment of diplomacy and of social events in political and media circles. In many cultures, it is viewed as an indispensable lubricant of business relationships. While members of elites certainly experience harm from their own or

others' drinking, for a variety of reasons the "harm per litre" is considerably less than among those who are poorer, lower status or marginalised (Schmidt et al., 2010), so that on the basis of personal experience a member of the elite can often easily discount the harms for society as a whole from drinking. The cultural position of alcohol in elite circles thus poses substantial challenges for approaches in terms of public health and public interest: in brief, alcohol is often the drug of choice for those responsible for writing and enforcing alcohol policies.

CHALLENGES IN IMPLEMENTING THE GLOBAL STRATEGY – WORLDWIDE AND AT A COUNTRY LEVEL

1. Money and resources. As noted above, at the international level there have been very limited resources for work on reducing harms from alcohol – in terms both of budgetary and extrabudgetary resources at WHO. Unlike other health-harming behavioural issues such as tobacco and sugar, there has also been almost no private benevolent funding for international programs on alcohol. Resources for implementation of prevention initiatives are also often lacking at the country level. Although excise taxes on alcoholic beverages are common, revenue from them is rarely earmarked for programs to reduce alcohol-related harm, though there have been a few examples – e.g., in Finland, Thailand and Washington state in the U.S. -- of small portions of government revenue from alcohol sales being earmarked for such purposes. Technical expertise in alcohol control measures is often lacking at national and subnational levels, but a substantial international and regional secretariat has been lacking to compile and disseminate technical knowledge. Thus, in the absence of philanthropic funding and limited WHO and other intergovernmental resources, there has been little investment in capacity building in low- and middle-income countries. Given the generally stigmatised nature of heavy drinking (Room, 2005c), in the last half-century there have been few civil society organisations prioritising alcohol as a health risk and prodding governments for action, as has been common for tobacco, nor has much philanthropic funding been forthcoming, so that civil society activity has been limited.

2.The need for and difficulty in implementing multisectoral approaches. Alcohol issues reach across many government departments and agencies, often with conflicting goals (Mäkelä & Viikari, 1977). As a consumer good, alcohol production and marketing is often overseen by a department of trade or industry. As a taxable commodity, alcoholic beverages are often in the jurisdiction of a finance or taxation department. In terms of drink-driving and alcohol-related crime, police, justice and corrections departments respond. Alcohol-involved harm to the family involves the welfare department. Areas like sports or tourism often have an alcohol angle, which will be under yet another jurisdiction. And, of course, the health department will be involved in health harms from alcohol. Jurisdiction over alcohol issues is often also split between levels of government. The national government may do the taxing, the state government may run the alcohol control system, and the policing may be at the local level. Alcohol issues are not likely to be viewed as central in any of the departments, so members of cross-departmental coordinating committees tend to be low-level staff. The division of labour in modern societies is efficient for many purposes, but hampers effective action in an area like alcohol-related harm which reaches across departments and agencies, but is not considered central to any of them (Room, 2018).

A common policy solution, when a cross-departmental area becomes politically significant, is to name a "czar" or high-level committee with cross-departmental powers, often located in a president's or premier's office – for instance, the Office of National Drug Control Policy in the U.S. Such an arrangement used to exist in France for alcohol: the Haut Comité d'Étude et d'Information sur l'Alcoolisme, created in 1954 in the President's office, but downgraded in 1987 to a Minister's office and abolished in 1991 (BnF

data, 2019). But "alcohol policy czars" with substantial powers to coordinate across departments are rare indeed in the current world. The general issue for any government, or for that matter at the international level, thus remains how best to organise a work program which will operate effectively in an area which reaches across departments or agencies.

Even within the health area, a parallel issue exists for alcohol problems, in that drinking is involved as a risk factor or an aspect of a disorder across aspects of health which are often in different branches of a health department or agency – for instance, infectious diseases, injuries, noncommunicable diseases and mental disorders (see Figure 2 above). Both at international and national levels, this has often raised difficulties in prioritisation and coordination. Further, alcohol in some countries has increasingly been defined as or subsumed under mental or behavioural health; this definition can lead to a focus on individual pathologies and individual-level solutions as opposed to population-level policy approaches.

3. The lack of clear targets and substantive goals in the Global Strategy. How different the situation for alcohol is from that of tobacco can be seen in WHO's Global Action Plan for noncommunicable diseases 2013-2020 (WHO, 2013). The "policy options for member states" on tobacco (pp. 30-31) include concrete targets keyed to provisions in the Framework Convention on Tobacco Control, such as "legislate for 100% tobacco smoke-free environments in all indoor workplaces…", and "implement comprehensive bans on tobacco advertising, promotion and sponsorship…".   The policy options for alcohol (pp. 34-35) are at a much more general level: "develop and implement comprehensive and multisectoral national policies and programmes to reduce the harmful use of alcohol", with a listing of the 10 target area headings in the Global Strategy. Many countries have been able to show progress on their implementation of the strategy simply by adopting a national plan, regardless of whether it commits to any concrete actions. And focus on the "best buys" has been very scarce.

CURRENT REALITIES NOT PROPERLY ADDRESSED BY THE GLOBAL STRATEGY

1. Trade and investment treaties. Alcohol is treated as an ordinary commodity in trade treaties and disputes and in the World Trade Organization. Besides the global treaties under the WTO's jurisdiction, there is a growing proliferation of multi- and bilateral trade agreements and investment treaties with provisions such as investor/state dispute settlement processes and e-commerce protections whose application have the potential to restrict national and subnational alcohol market controls. Given the generality of its provisions, the Global Strategy on alcohol has rarely been cited as an authority in trade disputes. For instance, a study of "specific trade concerns" (STCs) raised concerning tobacco and alcohol in the WTO's Technical Barriers to Trade Committee found that over half (12/20) of the tobacco-related STCs since 2005 cited the Framework Convention on Tobacco Control, while only 3 of the 46 alcohol-related STCs since 2010 cited the Global Strategy on alcohol (O'Brien, 2019).   While there are often provisions in trade treaties for exceptions on the basis of public health issues, these provisions are rarely applied, and when applied are interpreted against the public health interest. If there is an alternative to the public health measure which is less disruptive to trade, the public health measure will be disallowed whether or not the alternative is effective in health terms (Labonte & Sanger, 2006).

Alcohol is the only widely-used strongly psychoactive substance which is not covered by an international treaty. All others are covered either by the international drug control conventions of 1961 and 1971 or by the Framework Convention on Tobacco Control (FCTC). The drug treaties outlaw trade in nonmedical drugs and impose strong controls on the international markets in pharmaceutical psychoactive drugs, requiring a government permit from the receiving country before a drug can be exported to it. The

substantial international consensus embodied in drug treaties is probably the major reason that none of the substances covered by the treaties have been the subject of a formal WTO trade dispute, although there is no wording in the treaties which would foreclose this. In much the same way, although the FCTC does not include language counteracting trade treaties, and there have been a number of trade disputes about tobacco, the existence of the FCTC has been a powerful argument in the public health interest in international disputes, for instance in support of the Australian legal requirement of plain packaging of cigarettes. A clear expression of international consensus on a priority for public health considerations concerning alcohol products, in the form of an international legally binding treaty, would be a strong argument for public health priority over trade considerations even in the absence of specific language on trade. It would of course be even stronger if the priority of public health over free-trade considerations were explicitly stated.

2. Urgency and specificity. The Global Strategy for alcohol has been quite general in its goals and specification of means, and did not give a strong enough signal of the need for urgent action. As a comparison, the FCTC is explicit about particular market control measures for states to endeavour to implement, and establishes a "floor" set of minimum actions that states commit to taking. With the promulgation of the "best buys" for alcohol as an NCD risk factor and in the SAFER technical package, there is some added specificity in WHO's policy advice for alcohol, but little in the way of additional resources. Thus far, the global strategy on alcohol has stimulated relatively little action on the "best buys". And the measures are still stated in quite general terms, e.g., "raise prices on alcohol through excise taxes", with no mention, for instance, of the need also to index the taxes to inflation and income, or discussion of issues such as tying taxes to ethanol content. Taxation has been the most frequently implemented of the "best buys", but tax increases have rarely been put in place for public health purposes, and revenues are even less commonly devoted to reducing and preventing alcohol-related harm. Marketing and availability have been largely neglected and are in urgent need of a response.

3. Alcohol and equity. The Global Strategy has little discussion of the interplay of alcohol and equity, and of the potential of alcohol policies to advance health equity. One apparent universal in human societies has been the gender disparity in alcohol consumption: that more men than women drink at all, and that men account for at least two-thirds of the alcohol consumption in most societies. Male drinking often disproportionately absorbs family resources (e.g., Saxena et al., 2003), and is associated with a reduced quality of life for the female partner (e.g., Callinan et al., 2019), and with harm to children (Laslett et al., 2017) – effects which raise issues of violation of human rights.

Another dimension of health inequity concerns affluence versus poverty. Generally speaking, drinking at all is associated with higher income at the level of individuals and families, and with living in a higher-income rather than a low-income country. The distribution of heavier versus lighter drinking by income levels varies between societies, both at the individual and at the societal levels, but the harm per litre of alcohol tends to be substantially greater in poorer than in richer societies (WHO, 2018 Global Status Report, p. 16), and within a society for poorer versus richer individuals and families -- both in high-income countries (e.g., Case & Deaton, 2017; Bellis et al., 2016) and in low- and middle income countries (Probst et al., 2018). In any society, reductions in drinking by poorer individuals and families contribute to health equity in the society more than reductions by richer individuals and families, and the same applies at the societal level in terms of health equity between societies (Schmidt et al., 2010).

4. Digital and social media. The growth of the digital world in recent years is in the process of transforming marketing, sales and delivery of alcoholic beverages. Alcohol marketing resources are increasingly being shifted to the digital arena, particularly through social marketing. Digital trade agreements, "designed to keep the digital domain, as far as possible, a regulation-free zone", pose new obstacles to national and subnational efforts to regulate the availability of alcohol (Kelsey, 2019). Meanwhile, within countries as well as across national borders, alcohol sales are increasingly being made electronically, with the home delivery of alcohol increasingly operating outside the constraints of traditional alcohol licensing and regulations (Dablanc et al., 2017; Dumont, 2019).

5. The role of economic operators. There is growing clarity that the alcohol industry and other economic actors have substantial influence on member states' international policies and actions with respect to alcohol, including in their actions in organs of the World Health Assembly (e.g., Room, 2005), and that this influence is negative from a public health perspective.   The beer and spirits industries are now dominated by a small number of supranational corporations, with economies larger than those of many nation states (Casswell, 2019a), and wine industry interests are also well represented in many national governments. When their interests are at stake, economic actors in the alcohol market are well positioned to influence national policies and delegations. The nature of interaction between the WHO Secretariat and the alcohol industry should be limited to a dialogue and exchange of information for achieving positive outcomes for public health. Interaction with the alcohol industry within a given framework should not lead to or imply "partnership", "collaboration" or any other similar type of engagement that could give the impression of a formal joint relationship, the reason being that such engagements would put at risk the integrity, credibility and independence of WHO's work.

OPPORTUNITIES FOR REDUCING ALCOHOL-RELATED HARM WORLDWIDE AND AT A COUNTRY LEVEL
1. There has been further evidence of the effectiveness and cost-effectiveness of the WHO "best buys" – increasing and indexing alcohol prices by taxes or other means; limiting the spatial and temporal availability of alcohol; and broadly restricting the advertising and promotion of alcoholic beverages. Apart from their effectiveness, one factor in WHO's identification of these as "best buys" is the minimal cost to a government of implementing them. For a government, taxation is in fact a gain rather than a cost, and consideration should be given to dedicating some of the added revenue to prevention and treatment or remediation of alcohol-related harms. Each of the three "best buys" is further discussed as a priority measure below.

2. Opportunities in the current environment of global institutions include the UN/WHO focus on NCDs and the UN adoption of the Sustainable Development Goals (SDGs; Collin & Casswell, 2016). The priority afforded NCDs in the WHO environment provides an opportunity for alcohol, the least acknowledged risk factor for NCDs, to increase its visibility on the global health agenda. This requires increased horizontal collaboration within the WHO Secretariat, complemented by civil society activity building coalitions across risk factor groups. The commitment to the SDGs provides the opportunity for a number of harms from alcohol, such as the contribution to injury, gendered violence and traffic crashes, to be made more visible and be responded to within the WHO and UN context. This requires both horizontal collaboration within WHO and collaboration with other UN agencies, particularly UNDP, complemented by civil society activity.

3. Increased awareness of the commercial determinants of health provides another opportunity. A growing focus on the actions of the tobacco, unhealthy food and alcohol industries (soon to be joined by commercial cannabis) includes increased recognition of commercial drivers of harm and of the importance of conflict of interest and industry interference as barriers to effective policy adoption and implementation. The focus on health taxes (Jamison et al., 2013) and economic benefits of investment in effective policy (WHO, 2018c) are two examples of growing recognition of the cross-industry commercial drivers of health.

Corporate capitalism is also under challenge in its current form, and there is potential leverage from the new UN thrust under the SDGs. On 27 September UNCTAD released a new report, *Trade and Development Report 2019: Financing a Global Green New Deal* (UNCTAD, 2019). The report's Overview (pp. i-xiv) proclaims "a climate for change" and essentially signals the end of the neoliberal era of governance by free markets. In pursuit of the Sustainable Development Goals, on which progress has fallen behind, the report states that "it is critical for governments across the world to reclaim policy space". The report thus argues that collective interests such as a "global green New Deal" must take priority over market and investment interests. The rethinking of global policy assumptions that this report signals potentially offers leverage for WHO and others acting on behalf of the public interest to push for increased and concerted action on public health and other public interests. This might, for instance, include new provisions and institutions in the governance of global trade to preserve and strengthen public health controls and conditions in international trade and commerce. A "Global Alcohol New Deal" is needed that resets the relationship between the alcohol industries, governments and their populations.

4. The widespread reductions in youth drinking. There is evidence from many high-income and some middle-income countries of a substantial reduction in drinking at all, and in level of drinking, among teenagers (Kraus et al., 2018; Pennay et al., 2018; Pape et al., 2018), and some evidence that, although there is more drinking as the cohort reaches its early 20s, levels of drinking may still be lower than in earlier cohorts at that age (e.g. Livingston et al., 2016; Radaev & Roschina, 2019). That the change is so widespread suggests the influence of broadly-applying trends, including such factors as the rise of digital and social media and appliances that access them, as well as secular changes in forms of relationship in the nuclear family (Kraus et al., 2019; Room et al., in press); but the literature is still more at the level of propounding than of testing hypotheses about explanations (e.g., Törrönen et al., 2019). Historically, big changes up and down in alcohol consumption have often been initiated and carried by a particular generation (e.g., Room, 1984). And there are clear historical precedents for parallel changes in different societies (e.g., Mäkelä et al., 1981:7-9), although not as widespread as the current reductions in youth drinking.

PRIORITIES FOR ACTION TO REDUCE ALCOHOL-RELATED HARM WORLDWIDE AND AT THE COUNTRY LEVEL

1. Market control measures. A primary and effective means of limiting harms from alcohol is by limiting the availability of alcohol (Babor et al., 2010). A direct method for doing this is by a government monopoly, which potentially contributes to public health and order in a number of ways (Room & Cisneros-Örnberg, in press), and has been shown to be an effective means of alcohol control (Hahn et al., 2012; Her et al., 1999). Alternatively, a government wishing to control the market, including at the retail level, can license and regulate the sellers and servers of alcohol. Limiting availability, in the terms of the number and positioning of outlets and of the hours and days of opening, is a proven means of limiting the harms from

alcohol. Rules on these matters are either legislated or attached to licenses to sell and/or serve. The extent to which licensing works well as a harm control measure is at least partly dependent on how limited the supply of licenses is (de Vocht et al., 2016). Where licenses are rarer, they will be worth more, and the licensee will have more at stake in complying with government rules on conditions of sale and service.

Traditional limits on availability are currently being disrupted in many countries by home delivery services for orders made on the internet or by phone (e.g., Dumont, 2019). There is an urgent need for governments to extend and adapt regulations to take account of home delivery, for instance requiring that the delivery be made by a licensed establishment's employees, and forbidding delivery to a child, to an intoxicated person, or when no-one is at home.

2. Measures affecting the price of alcohol (Babor et al., 2010). The traditional way for governments to affect the price of alcohol is through excise or other taxes on the commodity or its service – which also yields revenue to the government. Arising often from a complicated history, rates of taxation tend to differ considerably per unit of ethanol between one beverage type and another. In public health terms, since the risk of many alcohol-related health and social problems is based on the amount of ethanol consumed, there is a good argument for a "volumetric tax", where the tax is based on how much ethanol the bottle, can or drink contains (Sharma et al., 2017). An argument can also be made for increasing the tax per unit of ethanol for more concentrated beverages; an alcohol overdose is difficult with ordinary beer, but a real possibility with undiluted spirits (Mäkelä et al., 2011). In recent years, it has been shown that setting a minimum retail price per unit of ethanol also has positive public health results (Zhao et al., 2013), but in some contexts reduces a revenue stream to government.

3. Limiting marketing. Research on effects on alcohol consumption and alcohol-related harms from alcohol advertising and promotion is almost entirely limited to its effects on young people. This does not mean that such marketing does not influence population-level consumption and problems, only that this area remains under-researched. Communications theory extends the function of marketing to include a normalisation of alcohol and, indeed, of intoxication (Purves, 2017), which may in turn affect the uptake of other alcohol control policies. Options for limiting advertising and promotion range from a total ban, through a total ban with exceptions (the approach of the French Loi Evin, which provided in its original form a model for limiting industry innovation, since new exceptions/activities had to receive explicit government permission), to a range of partial restrictions, including time, location, content, audience, medium/channel, beverage, and event-specific restrictions. Evidence on the effectiveness of these is limited and results vary widely. However, there was sufficient evidence for WHO to term bans or comprehensive restrictions on advertising an effective and cost-effective "best buy" in the NCD strategy (WHO, 2017b). A PAHO Technical Note (PAHO, 2017, pp. 18-24) spells out in some detail the regulatory elements and techniques for implementing such a policy.

4. Measures and programs building on the downward trends in youth drinking. One option is the kind of fieldwork common in social work: to seek out social worlds of heavy drinking (Savic et al., 2016) within youth cohorts, and to work with allies within such worlds to cut or hold down drinking and avoid adverse consequences. VicHealth, a public health agency in an Australian state, is currently sponsoring evaluated initiatives in this line (VicHealth et al., 2019a; 2019b). Another option is to strengthen laws and practices discouraging teenage drinking, although avoiding heavy-handed measures likely to provoke resistant reactions. A third is to prioritise actions in and around institutions of higher education, where young adult

drinking patterns tend to be set and where there is a substantial evidence base regarding what is effective (NIAAA, 2016; Arria & Jernigan, 2018) Given that in many cultures a drinker's lifetime maximum of drinking on an occasion is often set in the decade of the 20s, measures and programs which are successful in limiting youth drinking have potentially longer-term effects.

5.   Promoting measures and their implementation to reduce alcohol's contribution to specific health and social problems. These include, for instance, drink-driving countermeasures, which have been developed in detail and well tested (Babor et al., 2010); measures to reduce alcohol-related intimate violence (Lippy & DeGue, 2016) and street violence (Shepherd, 2007; Droste et al., 2014); and measures to reduce alcohol-related infections (Kalichman, 2010).

LOOKING BEYOND THE GLOBAL STRATEGY: WHAT ELSE?

1. Challenges that countries face in setting limits on alcohol marketing within their borders underscore the need for a legally binding international instrument. As described above, in this age of digital and social media marketing, alcohol advertising and other marketing travels ever more easily across borders and is largely invisible to policy makers. Failure of the major social media platforms to set limits on alcohol marketing leaves these kinds of restrictions in the hands of government. In its 2011 Regional Plan to Reduce Harmful Use of Alcohol, the Pan American Health Organization (PAHO) recommended that countries: "(a) Designate a government agency to be responsible for enforcement of marketing regulations; (b) Encourage statutory regulation to restrict or ban, as appropriate, the marketing of alcoholic beverages, particularly to youth and vulnerable groups" (PAHO, 2011). A subsequent Technical Note recommended "a comprehensive legally-binding ban on all alcohol marketing" as "the only means to eliminate the risk of any exposure to alcohol marketing for those most in need of protection, such as youth and other groups in conditions of vulnerability" (PAHO, 2017). Beyond requiring that countries take steps towards such a ban within five years of signing, the Framework Convention on Tobacco Control further requires that countries where such a ban is constitutionally infeasible undertake "restrictions or a comprehensive ban on advertising, promotion and sponsorship originating from its territory with cross-border effects" (WHO, 2005). The FCTC thus provides a model for how to implement restrictions on cross-border marketing of alcohol within the framework of a binding international legal instrument.

2. The application of human rights laws and agreements to alcohol issues should be investigated and developed (Slattery, 2019). Issues include not only human rights of the drinker, but also of those adversely affected by or as a result of others' drinking.

3. A greater involvement of global civil society in alcohol matters is needed. Compared to related fields such as tobacco and illicit drugs, international civic action and advocacy organisations are relatively sparse in the alcohol field (Schmitz, 2015: Gneiting & Schmitz, 2016). Through blogs, and accessing resources to fund civil society participation in meetings and events such as the WHO Forum on Alcohol, Drugs and Addictive Behaviours, WHO should encourage greater involvement of and coordination between relevant civil society bodies at national and international levels.

4. The focus should not be on harmful use of alcohol but on alcohol control. The phrase "harmful use" in the current global strategy has a different meaning from the same phrase as defined in WHO's International Classification of Diseases, and wrongly implies that there is a clear separation between two

ways of using alcohol, "harmful" and non-harmful. As has become clear in recent years, there is no level of drinking which is without any health risks, though the risks with low levels of drinking are fairly small (Rehm & Imtiaz, 2016). Thus harm may eventuate from any level of drinking, though there is great variation between different drinking patterns in how often this will happen. The much-needed binding global instrument should be framed in terms of alcohol control.

5. Substantial effort and resources should be put into building the base of expertise needed for wide implementation and evaluation of evidence-based policies and practices. The following elements are needed:

a)   Identification, training and ongoing resourcing of a global network of alcohol researchers, civil society groups and professionals (from health and other sectors) working to improve alcohol control policy and implementation particularly in low- and middle-income countries;

b)   Development of technical assistance materials and provision of consultation at the country level in Ministries of Health and related government departments and agencies in the implementation of effective strategies;

c)   Development and training of networks of government officials and representatives of civil society, working across sectors and drawn from similar country backgrounds, to meet together over a period of time and work on advocacy, development and implementation of evidence-based alcohol control policies;

d)   Sponsorship of targeted research projects to fill in key gaps in the research needed to promote effective alcohol control policies and practices.

SPECIFIC GOALS AND TARGETS ARE NEEDED TO STRENGTHEN IMPLEMENTATION

1.   Goals and targets need to be spelled out much more concretely than in the current Global Strategy. The PAHO listing of key concepts, principles and regulatory elements and techniques for alcohol marketing control (PAHO, 2017) begins on this process for that particular strategy. Attention also needs to be paid to finding and describing exemplars of good practice in the implementation of particular control areas, for instance of licensing and enforcement for alcohol sales regulations.

2. Member states should be asked to provide an annual report on status and progress on particular goals and targets. To accomplish this, a relatively simple monitoring tool is needed, focused on the SAFER framework, which enables comparisons over time within countries and between countries. This will include key aspects of alcohol control legislation and regulations and the impact of these on the ground. For example, the design of taxation and the resulting impact on affordability of alcohol will be measured and reported. This tool will rely where possible on data in the public domain, but some new data collection may be required. The development and use of this tool will encourage processes to improve and standardise data collection within countries and enable a score card comparison approach between countries.

NEW MECHANISMS, TOOLS AND ACTIVITIES NEEDED TO ADVANCE ALCOHOL CONTROL GLOBALLY AND AT THE COUNTRY LEVEL

1. There is a need for global normative law on alcohol at the intergovernmental level. The eventual aim should be a legally binding international instrument committing countries and resources to effective approaches to reducing alcohol-related harm. The purposes of the law are:

           * to counterbalance and constrain negative effects on alcohol control policy of international trade and economic laws;

           * as a strong symbolic statement, denormalising alcohol as a commodity and foodstuff;

           * to create a normative baseline and foster international cooperation in controlling the market;

           * to create an institutional framework – an intergovernmental forum, and a secretariat with resources to lead, demonstrate and mentor concerning preventive laws, institutions and practices.

The health framing for international agreement and action on alcohol should be kept, but other relevant framings – welfare, crime, sustainable development -- should also be brought into play, with complementarity between the approaches and institutions involved.

The international agreements should include provisions for:

           * control of international alcohol trade resembling controls of psychoactive medications in the international drug treaties;

           * agreed minimum standards for domestic alcohol markets, including standards on taxation; on control systems limiting times and places of sale and service; and on advertising, promotion and sponsorship;

           * a clear statement of limits on the role of economic operators, as in Article 5.4 of the Framework Convention on Tobacco Control.

1.   An international alcohol control Secretariat associated with WHO should be funded and staffed to provide guidance to nations and subnational governments on controls of the alcohol market in the public health interest, and on effective prevention and harm reduction policies, regulations and programs.

2.   A primary need to accelerate global and national actions is for resources, to support international consultation and actions, and a global secretariat for the effort. Consideration should be given to an intergovernmental commitment to a global impost on alcohol to support this effort, with the use of the money raised by this to be governed internationally.

4. Setting up a Conference of Parties to provide global governance of the international alcohol market and on global, national and subnational measures to minimise harms from alcohol.

5. Alcohol problems are not only about health. To bring in and deal with other issues of welfare, criminal justice and human rights, longterm alliances need to be formed between WHO and other intergovernmental agencies, as is done for other "wicked" problems. This has happened to a limited extent in the past, e.g., with UNODC for specialised alcohol and drug treatment advice and programming. But it needs to be done much more systematically, in recognition of the substantial overlaps between health and other types of problems with and harms from alcohol.

REFERENCES

Advertising Age-Neustar (2018) 200 Leading National Advertisers 2018 Fact Pack. *Advertising Age*, June 25. http://digitalgabe.com/wp-content/uploads/2018/06/Top-200-Media-Spenders.pdf. Accessed 6 October, 2019.

Arria, A.M. & Jernigan, D.H. (2018) Addressing college drinking as a statewide public health problem: Key findings from the Maryland Collaborative. *Health Promotion Practice* 19(2):303-313.

Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Hill, L., Holder, H., Homel, R., Livingston, M., Österberg, E., Rehm, J., Room, R., and Rossow, I. (2010) *Alcohol: No Ordinary Commodity - Research and Public Policy.* 2nd ed. Oxford, etc.: Oxford UP.

Babor, T. F., Robaina, K. & Jernigan, D. (2015). The influence of industry actions on the availability of alcoholic beverages in the African region. *Addiction 110*(4): 561-571.

Bakke, Ø., & Endal, D. (2010). Vested interests in addiction research and policy alcohol policies out of context: drinks industry supplanting government role in alcohol policies in sub-Saharan Africa. *Addiction 105*(1): 22-28.

Bellis, M. A., Hughes, K., Nicholls, J., Sheron, N., Gilmore, I., & Jones, L. (2016). The alcohol harm paradox: using a national survey to explore how alcohol may disproportionately impact health in deprived individuals. *BMC Public Health 16*(1): 111.

BnF data (2019) France: Haut comité d'étude et d'information sur l'alcoolisme. (https://data.bnf.fr/fr/11863984/france_haut_comite_d_etude_et_d_information_sur_l_alcoolisme/ (accessed 8 October, 2019).

Callinan, S., Rankin, G., Room, R., Stanesby, O., Rao, G., Waleewong, O., Greenfield, T.K., Hope, A., and Laslett, A.M. (2019) Harms from a partner's drinking: an international study on adverse effects and reduced quality of life for women. *American Journal of Drug and Alcohol Abuse* 45(2):170-178.

Carah, N., Meurk, C., Males, M. & Brown, J. (2018). Emerging social media 'platform'approaches to alcohol marketing: a comparative analysis of the activity of the top 20 Australian alcohol brands on Facebook (2012-2014). *Critical Public Health 28*(1): 70-80.

Case, A. & Deaton, A. (2017) Mortality and morbidity in the 21st century. *Brookings Papers on Economic Activity* 2017(1):397-476.

Casswell, S. (2009) Alcohol industry and alcohol policy – the challenge ahead. *Addiction* 104(Suppl. 1):3-5.

Casswell, S. (2019a) Current developments in the global governance arena: where is alcohol headed? Journal of Global Health, 11 October. http://www.jogh.org/documents/issue201902/jogh-09-020305.htm

Casswell, S. (2019b) Global response to alcohol harm in the 21st Century: as yet, too little, too late. Presented at a Kettil Bruun Society conference on Public Health and the Global Governance of Alcohol, Melbourne Australia, 30 September-3 October.

Chisholm, D., Moro, D., Bertram, M., Pretorius, C., Gmel, G., Shield, K., & Rehm, J. (2018). Are the "best buys" for alcohol control still valid? An update on the comparative cost-effectiveness of alcohol control strategies at the global level. *Journal of Studies on Alcohol and Drugs 79*(4): 514-522.

Collin, J. & Casswell, S. (2016) Alcohol and the SDGs. *The Lancet* 387 (10038):2582-3.

Dablanc, L., Morganti, E., Arvidsson, N., Woxenius, J., Browne, M. & Saidi, N. (2017) The rise of on-demand 'Instant Deliveries' in European cities. *Supply Chain Forum: An International Journal* 18(4): 203-217.

De Looze, M., Raaijmakers, Q., Bogt, T.T., Bendtsen, P., Farhat, T., Ferreira, M., Godeau, E., Kuntsche, E., Molcho, M., Pförtner, T.K. & Simons-Morton, B. (2015). Decreases in adolescent weekly alcohol use in Europe and North America: evidence from 28 countries from 2002 to 2010. *European Journal of Public Health 25*(suppl. 2): 69-72.

De Vocht, F., Heron, J., Angus, C., Brennan, A., Mooney, J., Lock, K., Campbell, R. & Hickman, M. (2016) Measurable effects of local alcohol licensing policies on population health in England. *Journal of Epidemiology and Community Health 70*(3):231-237.

Droste, N., Miller, P. & Baker, T. (2014). Emergency department data sharing to reduce alcohol-related violence: A systematic review of the feasibility and effectiveness of community-level interventions. *Emergency Medicine Australasia 26*(4): 326-335.

Dumont, J. (2019) Why more retailers are raising a glass to alcohol delivery. Grocery Dive, April 29. https://www.grocerydive.com/news/why-more-retailers-are-raising-a-glass-to-alcohol-delivery/553064/ (accessed 9 October, 2019)

Dünnbier, M. & Sperkova, K., eds. (2016) Alcohol and the Sustainable Development Goals: Major obstacle to development. Stockholm: IOGT International. http://iogt.org/wp-content/uploads/2015/03/Alcohol-and-SDGs_new.pdf (accessed 27 September, 2019)

Esser, M.B. & Jernigan, D.H. (2015) Multinational alcohol market development and public health: Diageo in India. *American Journal of Public Health* 105(11):2220-2227.

Estonian Ministry of Social Affairs (2014) *Green Paper on Alcohol Policy*. Tallinn: Ministry of Social Affairs. https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Tervislik_eluviis/alkoholi_roheline_raamat-19.02.14_12_en.pdf (accessed 7 October, 2019).

Fickensher, L. (2018) Celebs hawking Ciroc vodka didn't mention paid ad deal: watchdog. New York Post. https://nypost.com/2018/12/11/celebs-hawking-ciroc-vodka-didnt-mention-paid-ad-deal-ftc/. Accessed October 6, 2019.

GBD 2017 Risk Factors Collaborators (2018) Global, regional, and national comparative risk assessment of 84 behavioural, environmental and occupational, and metabolic risks or clusters of risks for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. *The Lancet* 392: 1923–1994.

Gneiting, U. & Schmitz, H.P. (2016) Comparing global alcohol and tobacco control efforts: Network formation and evolution in international health governance. *Health Policy and Planning* 31(suppl 1):i98-i109.

Gilmore, A.B., Fooks, G. & McKee, M. (2011). A review of the impacts of tobacco industry privatisation: implications for policy. *Global Public Health 6*(6): 621-642.

Gopakumar, K. M. (2019) WHO's engagements with alcohol industry: an analysis in the light of FENSA provisions. Presented at a conference, Public Health and the Global Governance of Alcohol, Melbourne, 30 September – 3 October.

Gostin, L. O., Sridhar, D. & Hougendobler, D. (2015) The normative authority of the World Health Organization. *Public Health 129*(7): 854-863.

Hahn, R.A., Middleton, J.C., Elder, R., Brewer, R., Fielding, J., Naimi, T.S., Toomey, T.L., Chattopadhyay, S., Lawrence, B., Campbell, C.A. and Community Preventive Services Task Force (2012) Effects of alcohol retail privatization on excessive alcohol consumption and related harms: a community guide systematic review. *American Journal of Preventive Medicine 42*(4):418-427.

Handley, L. (2018) Diageo pulls Snapchat advertising globally as UK bans alcohol ad for appealing to under-18s. CNBC. https://www.cnbc.com/2018/01/03/diageo-pulls-snapchat-adverts-globally-as-uk-bans-captain-morgan-ad.html. Accessed October 6, 2019.

Her, M., Giesbrecht, N., Room, R. & Rehm, J. (1999) Privatizing alcohol sales and alcohol consumption: evidence and implications. *Addiction 94*(8):1125-1139.

Jamison, D.T., Summers, L.H., Alleyne, G., Arrow, K.J., Berkley, S., Binagwaho, A., Bustreo, F., Evans, D., Feachem, R.G., Frenk, J. & Ghosh, G. (2013) Global health 2035: a world converging within a generation. *The Lancet 382*(9908):1898-1955.

Jernigan, D.H. & Babor, T.F. (2015). The concentration of the global alcohol industry and its penetration in the African region. *Addiction 110*(4): 551-560.

Jernigan, D.H. & Rushman, A.E. (2014) Measuring youth exposure to alcohol marketing on social networking sites: challenges and prospects. *Journal of Public Health Policy* 35(1):91-104.

Jernigan, D. & Trangenstein, P. (2017) Global developments in alcohol policies: Progress in implementation of the WHO Global Strategy to Reduce the Harmful Use of Alcohol since 2010. Geneva: World Health Organization. http://www.who.int/substance_abuse/activities/fadab/msb_adab_gas_progress_report.pdf?ua=1. Accessed 6 October, 2019.

Jernigan, D., Noel, J., Landon, J., Thornton, N. & Lobstein, T. (2017) Alcohol marketing and youth alcohol consumption: a systematic review of longitudinal studies published since 2008. *Addiction* 112:7-20.

Kalichman, S.C. (2010). Social and structural HIV prevention in alcohol-serving establishments: review of international interventions across populations. *Alcohol Research & Health 33*(3): 184-194.

Katikireddi, S.V., Whitley, E., Lewsey, J., Gray, L. & Leyland, A.H. (2017) Socioeconomic status as an effect modifier of alcohol consumption and harm: analysis of linked cohort data. *Lancet Public Health* 2(6):e267-e276. doi: 10.1016/S2468-2667(17)30078-6.

Kelsey, J. (2012). New-generation free trade agreements threaten progressive tobacco and alcohol policies. *Addiction 107*(10): 1719-1721.

Kelsey, J. (2019) Digital trade agreements pose new obstacles to regulating alcohol policy in the digital age. Presented at a conference, Public Health and the Global Governance of Alcohol, Melbourne, Australia, 30 September – 3 October.

Kraus, L., Seitz, N.N., Piontek, D., Molinaro, S., Siciliano, V., Guttormsson, U., Arpa, S., Monshouwer, K., Leifman, H., Vicente, J. and Griffiths, P. (2018) 'Are the times a-changin'? Trends in adolescent substance use in Europe. *Addiction 113*(7):1317-1332.

Kraus, L., Room, R., Livingston, M., Pennay, A., Holmes, J. & Törrönen, J. (early view, 2019) Long waves of consumption or a unique social generation? Exploring recent declines in youth drinking. *Addiction Research and Theory*, online, 8 July, 2019. DOI:10.1080/16066359.2019.1629426.

Labonte, R. & Sanger, M. (2006). Glossary of the World Trade Organisation and public health: part 1. *Journal of Epidemiology & Community Health*, *60*(8), 655-661,

Lashbrook, A. (2019) How Instagram can make quitting drinking harder. Medium:OneZero. https://onezero.medium.com/how-instagram-can-make-quitting-drinking-harder-38f1e737d6fd. Accessed October 6, 2019.

Laslett, A.-M., Rankin, G., Waleewong, O., Callinan, S., Hoang, H.T.M., Florenzano, R., Hettige, S., Obot, I., Siengsounthone, L., Ibanga, A., Hope, A., Landberg, J., Hanh, T.M.V., Thamarangsi, T., Rekve, D. & Room, R. (2017) A multi-country study of harms to children because of others' drinking. *Journal of Studies on Alcohol and Dru*gs 78:195-202.

Lincoln, M. (2016). Alcohol and drinking cultures in Vietnam: a review. *Drug and Alcohol Dependence 159:* 1-8.

Lippy, C., & DeGue, S. (2016). Exploring alcohol policy approaches to prevent sexual violence perpetration. *Trauma, Violence & Abuse 17*(1): 26-42.

Livingston, M., Raninen, J., Slade, T., Swift, W., Lloyd, B., & Dietze, P. (2016). Understanding trends in Australian alcohol consumption—an age–period–cohort model. *Addiction 111*(9): 1590-1598.

Lobstein, T., Landon, J., Thornton, N., & Jernigan, D. (2017) The commercial use of digital media to market alcohol products: a narrative review. *Addiction 112*:21-27.

Mäkelä, K. & Viikari, M. (1977). Notes on alcohol and the state. *Acta Sociologica 20*(2): 155-179.

Mäkelä, K., Room, R., Single, E., Sulkunen, P. & Walsh, B., with 13 others (1981) *Alcohol, Society and the State: I. A Comparative Study of Alcohol Control*. Toronto: Addiction Research Foundation.

Mäkelä, P., Hellman, M., Kerr, W.C. & Room, R. (2011) A bottle of beer, a glass of wine, or a shot of whiskey? Can the rate of alcohol-induced harm be affected by altering the population's beverage choices? *Contemporary Drug Problems 38*(4):599-619.

Manthey, J., Shield, K. D., Rylett, M., Hasan, O. S., Probst, C., & Rehm, J. (2019, online). Global alcohol exposure between 1990 and 2017 and forecasts until 2030: a modelling study. *The Lancet*. http://dx.doi.org/10.1016/S0140-6736(18)32744-2 (accessed 22 September, 2019)

McClure, A.C., Tanski, S.E., Jackson, K.M., & Sargent, J.D. (2013) TV and internet alcohol marketing and underage alcohol use. *Alcoholism: Clinical and Experimental Research* 37(Suppl. 2):13A.

McClure, A.C., Tanski, S.E., Li, Z. et al. (2016) Internet alcohol marketing and underage alcohol use. *Pediatrics* 137(2):e20152149.

Murray, C.J.L. & Lopez, A. (1996) Quantifying the burden of disease and injury attributable to ten major risk factors. In: Murray ,C.J.L. & Lopez, A.D., eds. *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries and Risk Factors in 1990 and Projected to 2020*, pp. 295-324. Boston: Harvard School of Public Health on Behalf of the World Health Organization and the World Bank.

Nemtsov, A., Neufeld, M., & Rehm, J. (2019). Are trends in alcohol consumption and cause-specific mortality in Russia between 1990 and 2017 the result of alcohol policy measures? *Journal of Studies on Alcohol and Drugs* 80(5): 489–498. doi: 10.15288/jsad.2019.80.489

NIAAA (2016) *Planning Alcohol Interventions Using NIAAA'S CollegeAIM-Alcohol Intervention Matrix*. Rockville, MD: National Institute on Alcohol Ause and Alcoholism, NIH Publication No. 15-AA-8017. https://www.collegedrinkingprevention.gov/CollegeAIM/Resources/NIAAA_College_Matrix_Booklet.pdf (accessed 12 October, 2019).

Niland, P., McCreanor, T., Lyons, A., & Griffin, C. (2017). Alcohol marketing on social media: Young adults engage with alcohol marketing on Facebook. *Addiction Research & Theory 25*(4): 273-284.

O'Brien, P., Gleeson, D., Room, R., & Wilkinson, C. (2017). Marginalising health information: implications of the Trans-Pacific Partnership Agreement for alcohol labelling. *Melbourne University Law Review 41*: 341-391. https://law.unimelb.edu.au/__data/assets/pdf_file/0009/2494341/09-OBrien-et-al.pdf

O'Brien, P. & Mitchell, A. D. (2018). On the bottle: Health information, alcohol labelling and the WTO Technical Barriers to Trade Agreement. *QUT Law Review 18:* 124-155.

O'Brien, P. (2019) Informal dispute settlement in international trade law: The Global Strategy to Prevent the Harmful Use of Alcohol and the Framework Convention on Tobacco Control compared, presented at a conference, Public Health and the Global Governance of Alcohol, Melbourne, Australia, 30 September – 3 October.

PAHO (2011) *Plan of Action to Reduce the Harmful Use of Alcohol.* Washington, D.C.: Pan American Health Organization.

PAHO (2017) Technical Note: Background on Alcohol Marketing Regulation and Monitoring for the Protection of Public Health. Washington, DC: Pan American Health Organization. http://iris.paho.org/xmlui/handle/123456789/33972. Accessed October 12, 2019.

Pape, H., Rossow, I. & Brunborg, G.S. (2018). Adolescents drink less: How, who and why? A review of the recent research literature. *Drug and Alcohol Review 37*: S98-S114.

Parna, K. (in press) Alcohol consumption and alcohol policy in Estonia 2000-2017 in the context of the Baltic and Nordic countries, *Drug and Alcohol Review.*

Pennay, A., Holmes, J., Törrönen, J., Kraus, L. & Room, R. (2018) Researching the decline in adolescent drinking: The need for a global and generational approach. *Drug and Alcohol Review* 37 (Suppl. 1), S115-S119.

Probst, C., Parry, C.D.H., Wittchen, H.U. & Rehm, J. (2018) The socioeconomic profile of alcohol-attributable mortality in South Africa: a modelling study. *BMC Med.* 16(1):97. doi: 10.1186/s12916-018-1080-0.

Purves, R (2017) Creating powerful brands. In: Lyons, A., McCreanor, T., Goodwin, I. & Moewaka Barnes, H., eds. *Youth Drinking Cultures in a Digital World: Alcohol, Social Media and Cultures of Intoxication*, pp. 147-164. Oxford & New York: Routledge.

Radaev, V. & Roshchina, Y. (2019) Young cohorts of Russians drink less: age–period–cohort modelling of alcohol use prevalence 1994–2016. *Addiction*, *114*(5), 823-835.

Rehm, J. & Imtiaz, S. (2016) Alcohol consumption as a risk factor for global burden of disease. A narrative review. *Substance Abuse Treatment, Prevention and Policy* 11:37. doi: 10.1186/s13011-016-0081-2 [PMID: 27793173]

Rehm, J., Gmel Sr., G., Gmel, G., Hasan, O.S.M., Imtiaz, S., Popova, S., Probst, C., Roerecke, M., Room, R., Samokhvalov, A.V., Shield, K.D., & Shuper, P.A. (2017). The relationship between different dimensions of alcohol use and the burden of disease - an update. *Addiction* 112(6): 968–1001. doi:10.1111/add.13757 [PMID: 28220587]

Rehm, J., Hasan, O.S.M., Imtiaz, S., Probst, C., Roerecke, M. & Shield, K.D. (2018). Alcohol and noncommunicable disease risk. *Current Addiction Reports* 5(1): 72-85. doi: 10.1007/s40429-018-0189-8

Rehm, J., Manthey, J., Lange, S., Badaras, R., Zurlyte, I., Passmore, J., Breda, J., Ferreira-Borges, C., & Štelemėkas, M. (2019a). Alcohol control policy and changes in alcohol-related traffic harm. *Addiction*, doi: 10.1111/add.14796. [Epub ahead of print Oct 3] [PMID: 31475395]

Rehm, J., Štelemėkas, M. & Badaras, R. (2019b). Research protocol to evaluate the effects of alcohol policy changes in Lithuania. *Alcohol and Alcoholism* 54(1): 112–118. doi: 10.1093/alcalc/agy068 [PMID: 30260375]

Room, R. (1984) A 'reverence for strong drink': the Lost Generation and the elevation of alcohol in American culture. *Journal of Studies on Alcohol* 45:540-546.

Room, R. (2005a) Alcohol and the World Health Organization: the ups and downs of two decades.   *Nordisk Alkohol- & Narkotikatidskrift* 22 (English supplement):146-162.

Room, R. (2005b) Negotiating the place of alcohol in public health: the arguments at the interface. *Addiction* 100:1396-1397.

Room, R. (2005c) Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review* 24:143-155.

Room, R. (2018) Relevant to all disciplines and professions but central to none: how may social alcohol and drug research flourish? *Nordic Studies on Alcohol and Drugs* 35(2):104-107.

Room, R. (2019) Global intergovernmental action to minimise alcohol problems: the back story. Presented at a Kettil Bruun Society conference on Public Health and the Global Governance of Alcohol, Melbourne Australia, 30 September-3 October.

Room, R. & Cisneros Örnberg, J. (in press) Government monopoly as an instrument for public health and welfare: Lessons for cannabis from experience with alcohol monopolies, *International Journal of Drug Policy*, forthcoming.

Room, R., Greenfield, T.K., Holmes, J., Kraus, L., Livingston, M., Pennay, A. & Törrönen, J. (in press) Supranational changes in drinking patterns: Factors in explanatory models of substantial and parallel social change. *Addiction Research and Theory*, forthcoming.

Savic, M., Room, R., Mugavin, J., Pennay, A. & Livingston, M. (2016). Defining "drinking culture": A critical review of its meaning and connotation in social research on alcohol problems. *Drugs: Education, Prevention and Policy 23*(4): 270-282.

Saxena, S., Sharma, R. & Maulik, P. K. (2003) Impact of alcohol use on poor families: a study from north India. *Journal of Substance Use 8*(2): 78-84.

Schmidt, L., Mäkelä, P., Rehm, J. & Room, R. (2010) Alcohol: equity and social determinants. In: Blas, E. & Sivasankara Kurup, A., eds., *Equity, Social Determinants and Public Health Programmes,* pp. 11-29.

Geneva: World Health Organization.
http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf

Schmitz, H.P. (2015) The global health network on alcohol control: Successes and limits of evidence-based advocacy. *Health Policy and Planning* 31(suppl 1):i87-i97.

Sharma, A., Sinha, K., & Vandenberg, B. (2017) Pricing as a means of controlling alcohol consumption. *British Medical Bulletin* 123:149-158.

Shield, K.D., Rylett, M., & Rehm, J. (2016). *Public Health Successes and Missed Opportunities: Trends in Alcohol Consumption and Attributable Mortality in the WHO European Region, 1990-2014*. Copenhagen, Denmark: WHO European Region. http://www.euro.who.int/__data/assets/pdf_file/0018/319122/Public-health-successes-and-missed-opportunities-alcohol-mortality-19902014.pdf

Shepherd, J. (2007). Preventing alcohol-related violence: a public health approach. *Criminal Behaviour and Mental Health 17*(4): 250-264.

Slattery, C. (2019) Using the Sustainable Development agenda and human rights law to progress alcohol control, presented at a conference on Public Health and the Global Governance of Alcohol, Melbourne, Australia, 30 September – 3 October.

Slezak, M. (2019) Workshop to implement the law for prevention and control of alcohol related harms. *Viet Nam News*, 16 October. https://vietnamnews.vn/society/537000/workshop-to-implement-the-law-for-prevention-and-control-of-alcohol-related-harms.html#geP6iGWPYqb7f9CF.97

Sornpaisarn, B., Shield, K.D., Cohen, J.E., Schwartz, R. & Rehm, J. (2015). Can pricing deter adolescents and young adults from starting to drink: an analysis of the effect of alcohol taxation on drinking initiation among Thai adolescents and young adults. *Journal of Epidemiology and Global Health* 5(4 Suppl 1): S45-S57. doi: 10.1016/j.jegh.2015.05.004. PMID: 26079927

Sornpaisarn, B., Shield, K.D., Cohen J.E., Schwartz, R. & Rehm, J. (2016). The association between taxation increases and changes in alcohol consumption and traffic fatalities in Thailand. *Journal of Public Health* 38(4): e480–e488. doi: 10.1093/pubmed/fdv163 [PMID: 26590388]. [PMID: 28158682]

United Nations (2011) UN High-level Meeting on Noncommunicable Disease Prevention and Control, 19-20 September. New York: United Nations. https://www.who.int/nmh/events/un_ncd_summit2011/en/ (accessed 6 October 2019)

UNCTAD (2019) *Trade and Development Report 2019: Financing a Global Green New Deal*. New York: United Nations Conference on Trade and Development. https://unctad.org/en/PublicationsLibrary/tdr2019_en.pdf (accessed 28 September, 2019)

VicHealth, Centre for Alcohol Policy Research and Alcohol and Drug Foundation (2019a) *Alcohol Cultures Framework background paper – A framework to guide public health action on risky drinking Cultures.* Revised edition. Melbourne: Victorian Health Promotion Foundation. https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/alcohol-misuse/Alcohol-Culture-Change-framework/VicHealth-AlcoholCulturesBackgroundPaper_2019.pdf?la=en&hash=CD889DD350509B4F5C00EAEEB062AB6DA7B3E73F (accessed 28 September, 2019)

VicHealth (2019b) Alcohol Strategy 2019-2023. Melbourne: Victorian Health promotion Foundation. https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/Action-Agenda/Alcohol-Strategy-2019.pdf?la=en&hash=84351ACE727E7CFAACD64278726445610CF1024B (accessed 28 September, 2019)

VNS (2019) workshop to implement the law for prevention and control of alcohol-related harms. Viet Nam News, 16 October. https://vietnamnews.vn/society/537000/workshop-to-implement-the-law-for-prevention-and-control-of-alcohol-related-harms.html#geP6iGWPYqb7f9CF.97moem

World Health Assembly (2005) Resolution WHA 58.26, "Public health problems caused by the harmful use of alcohol",

https://www.who.int/substance_abuse/wha_resolution_58_26_public_health_problems_alcohol.pdf?ua=1 (accessed 6 October, 2019)

World Health Organization (2005) *Framework Convention on Tobacco Control.* Geneva: WHO. https://apps.who.int/iris/bitstream/handle/10665/42811/9241591013.pdf?sequence=1 (accessed 6 October, 2019)

World Health Organization (2010) *Global Strategy to Reduce the Harmful Use of Alcohol*. Geneva: WHO. (Whttps://www.who.int/substance_abuse/activities/gsrhua/en/

World Health Organization (2013) *Global Action Plan for the Prevention and Control of NCDs 2013-2020*. Geneva: WHO. https://apps.who.int/iris/bitstream/handle/10665/94384/9789241506236_eng.pdf;jsessionid=0047163F7C5851F227743F007D87AFEB?sequence=1

World Health Organization (2017a) Montevideo Roadmap 2018-2030 on NCDsa a Sustainable Development Priority. Geneva: WHO. https://www.who.int/conferences/global-ncd-conference/Roadmap.pdf

World Health Organization (2017b) *Tackling NCDs: 'Best buys' and other recommended interventions for the prevention and control of NCDs*. Geneva: WHO. https://apps.who.int/iris/bitstream/handle/10665/259232/WHO-NMH-NVI-17.9-eng.pdf?sequence=1

World Health Organization (2018a) *Global Status Report on Alcohol and Health 2018*. Geneva: WHO. https://www.who.int/substance_abuse/publications/global_alcohol_report/en/

World Health Organization (2018b) SAFER: Preventing and reducing alcohol-related harm. Geneva: WHO. https://www.who.int/docs/default-source/alcohol/sagfer-framework.pdf?sfvrsn=3d085e49_4 (accessed 27 September, 2019)

World Health Organization (2018c) Saving lives, spending less: A strategic response to noncommunicable diseases. Geneva: WHO. https://apps.who.int/iris/bitstream/handle/10665/272534/WHO-NMH-NVI-18.8-eng.pdf (accessed 12 October, 2019)

World Health Organization (2019a) Governance: Assignment given to the WHO Secretariat by the World Health Assembly. Geneva: WHO. https://www.who.int/substance_abuse/activities/globalstrategy/en/ (accessed 27 September, 2019)

World Health Organization (2019b) Noncommunicable Diseases: Campaign for Action -- Meeting the NCD Targets. Geneva: WHO. https://www.who.int/nmh/events/un_ncd_summit2011/en/ (accessed 6 October, 2019)

World Health Organization Executive Board (2017) Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018: Report by the Director-General. Geneva: WHO. http://apps.who.int/gb/ebwha/pdf_files/EB142/B142_15-en.pdf (accessed 12 October, 2019).

World Health Organization Regional Office for Europe (2019). *Alcohol Policy Impact Case Study: The Effects of Alcohol Control Measures on Mortality and Life Expectancy in the Russian Federation.* http://www.euro.who.int/en/publications/abstracts/alcohol-policy-impact-case-study-the-effects-of-alcohol-control-measures-on-mortality-and-life-expectancy-in-the-russian-federation-2019 (accessed 6 October, 2019)

Zhao, J., Stockwell, T., Martin, G., Macdonald, S., Vallance, K., Treno, A., Ponicki, W.R., Tu, A. & Buxton, J. (2013). The relationship between minimum alcohol prices, outlet densities and alcohol-attributable deaths in British Columbia, 2002–09. *Addiction 108*(6):1059-1069.